

1 GREGORY A. BROWER
2 United States Attorney
3 ROGER W. WENTHE
4 Assistant United States Attorney
5 Nevada Bar No. 8920
6 333 Las Vegas Blvd. So., #5000
7 Las Vegas, Nevada 89101
8 Ph: (702) 388-6336
9 Fax: (702) 388-6787

10 Attorneys for the United States.

11 **UNITED STATES DISTRICT COURT
12 DISTRICT OF NEVADA**

13
14 UNITED STATES OF AMERICA,)
15)
16 Plaintiff,)
17)
18 v.) Case No.
19)
20 MILLER MEDICAL GROUP, CHTD.,)
21)
22 Defendant.)
23 _____)
24
25

26 **COMPLAINT**

1 Plaintiff, the United States of America, for its Complaint against Defendant Miller
2 Medical Group, Chtd. (MMG), alleges as follows:

3 **JURISDICTION AND VENUE**

4 1. This action arises under the False Claims Act (FCA), as amended, 31 U.S.C.
5 §3729 *et seq.*, and the common law. The Court has subject-matter jurisdiction over this matter
6 pursuant to 31 U.S.C. §3730 and 28 U.S.C. §1345.

7 2. The Court has personal jurisdiction over the defendant because it
8 regularly conducts business in the State of Nevada and in the United States of America.

9 3. Venue is proper in this district under 28 U.S.C. §1391(b) and (c), because
10 defendant can be found, resides, or transacts business within this district and the acts proscribed
11 by the FCA and the common law occurred within this district.

PARTIES

4. Plaintiff, the United States of America (United States) is acting on behalf of the Department of Health and Human Services (HHS). HHS is an agency and instrumentality of the United States, and its activities, operations, and contracts are paid from federal funds. At all times material to this action, HHS contracted with insurance carriers to act as its agents in administering Part B of the Medicare program within the State of Nevada. The United States is also acting on behalf of the Office of Personnel Management (OPM), an agency within the Department of the Treasury. At all times material to this action, OPM contracted with insurance carriers to administer Federal Employee Health Benefit (FEHB) programs.

5. Defendant MMG is a Nevada corporation which does business under the name Internal Medicine Associates. MMG is engaged in the business, among others, of providing health care and laboratory services to individual patients.

OPERATION OF THE MEDICARE PROGRAM

6. Title XVIII of the Social Security Act, 42 U.S.C. §1395 *et seq.*, establishes the Health Insurance for the Aged and Disabled program, popularly known as Medicare.

7. Medicare is comprised of two principal parts. Part A of Medicare, which is not involved in this matter, provides hospitalization insurance for eligible individuals. 42 U.S.C. §§ 1395c - 1395i. Part B of Medicare is a voluntary subscription program of supplementary medical insurance covering items and services other than hospitalization, such as charges for medical care in physicians' offices. The Part B program covers only those services and procedures which have been determined to be medically reasonable and necessary. 42 U.S.C. 1395y(a)(1)(A). The Part B program requires beneficiaries to bear some of the cost of their care to prevent overutilization, and, accordingly, Part B generally covers 80% of the reasonable charges as established by a physician fee schedule, with the patient responsible for the remaining 20%. 42 U.S.C. § 1395l(a)(1).

8. During the relevant time period, physicians and other health care providers who

1 provided services to Medicare Part B beneficiaries presented a claim for reimbursement to the
2 United States by presenting the claim to the appropriate Medicare carrier, which acted as the
3 agent of the Secretary of HHS. The claim was presented using Form HCFA 1500, either by mail
4 or electronically. The claim was paid by the Medicare carrier directly from the United States
5 Treasury. Each HCFA 1500 detailed the provider's identifying information, the date and type of
6 service, procedure, or supplies provided, the diagnosis of the patient, and the amount of
7 reimbursement sought. Providers who submitted claims using Form HCFA 1500 or its
8 electronic equivalent affirmatively certified that the services described were actually performed
9 by the submitting provider and were medically indicated and necessary.

10 9. Regulations adopted by the Centers for Medicare and Medicaid Services (CMS),
11 a department of HHS, require that the description of a provider's services and procedures must
12 be entered onto Form HCFA 1500 or its electronic equivalent by using procedure codes
13 published by the American Medical Association, known as the Physicians' Current Procedural
14 Terminology (CPT).

15 10. At all times material to this action, laboratories which performed blood analysis
16 services requested by a referring physician were permitted by Medicare regulations to bill for
17 and receive payment for those services in an amount set by the Medicare physician fee schedule.
18 To obtain payment, the laboratory was permitted to present a claim to the Medicare carrier for
19 the analysis using certain CPT Codes, as appropriate, depending on the type of blood analysis
20 performed.

21 **OPERATION OF THE FEHB PROGRAM**

22 11. The Federal Employee Health Benefits Act, 5 U.S.C. §§ 8901 - 8913, establishes
23 a comprehensive program to provide federal employees and retirees with subsidized health care
24 benefits, known as the Federal Employee Health Benefit (FEHB) program.

25 12. The United States Office of Personnel Management (OPM) administers the FEHB
26 program by contracting with various private health insurance carriers to develop health care

plans with varying coverages and costs. OPM collects federal employees' premiums and makes payment to FEHB contractors through the Federal Employee Health Benefits Fund, a part of the United States Treasury. 5 U.S.C. § 8909.

13. Health care providers who seek reimbursement from FEHB program health care plans typically utilize form HCFA 1500, using the CPT procedure codes described above. Providers who submit claims to FEHB program health care plans using Form HCFA 1500 affirmatively certify that the services described were actually performed by the submitting provider and were medically indicated and necessary.

14. Medicare and the FEHB program are collectively referred to herein as the federal health care benefit programs.

FACTUAL ALLEGATIONS

15. During the period from January 1, 2003, through December 31, 2006, defendant performed services for federal health care beneficiaries but prepared or caused to be prepared materially false or fraudulent records or statements, and presented or caused to be presented to the United States materially false or fraudulent claims for reimbursement, as described in the following paragraphs.

16. During the relevant time period, a “lipid panel” analysis was a laboratory analysis of a sample of a patient’s blood. The CPT code number applicable to a lipid panel was 80061. In order to submit a claim using CPT Code 80061 to Medicare for performing a lipid panel, the test had to be medically reasonable and necessary, and the laboratory was required to measure the patient’s total serum cholesterol, high-density lipoprotein (HDL) level , and triglyceride level. The patient’s low-density lipoprotein level (LDL) could also be calculated from the triglyceride level with reasonable accuracy in most cases by using a mathematical formula.

17. During the relevant time period, a patient's LDL could be directly measured by use of a separate analysis, when necessary. The CPT Code for a direct LDL analysis was 83721.

1 Medicare and FEHB policy provided that a directly measured LDL would not be appropriate,
2 and therefore payment would be denied, if the direct LDL analysis was performed on the same
3 day for a patient who had received a lipid panel test, unless the patient's triglyceride level was
4 too high to permit reasonably accurate calculation of the LDL level. The generally accepted
5 triglyceride level which was considered to high to permit reasonably accurate calculation of the
6 LDL level was 400 mg/dL.

7 18. In or about January 2003, MMG adopted a policy for its laboratory under which
8 each patient who was prescribed a lipid panel analysis by his or her physician would
9 automatically receive both a lipid panel analysis and a directly measured LDL analysis,
10 regardless of the patient's level of triglycerides. MMG then submitted a claim to the patient's
11 insurers, including Medicare and FEHB, using both CPT Codes 80061 and 83721.

12 19. Defendant prepared or caused to be prepared materially false or fraudulent
13 records and statements and presented or caused to be presented materially false or fraudulent
14 claims to the United States using CPT Code 83721, even though defendant knew or had reason
15 to know that a directly measured LDL analysis was not medically appropriate under the
16 circumstances.

17 20. Based on the express materially false or fraudulent certifications made by or on
18 behalf of defendant on HCFA 1500 forms it caused to be presented, or their equivalent, and
19 where applicable based also on the material false or fraudulent records and statements it prepared
20 or caused to be prepared, the United States paid reimbursements to defendant from the United
21 States Treasury based on claims using CPT Code 83721 which would not have been paid had
22 defendant provided truthful information.

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24 **FIRST CLAIM FOR RELIEF**

25 **False Claims Act**

26 21. The United States adopts and incorporates by reference the allegations of

1 paragraphs 1 through 20 above as though set forth fully herein.

2 22. During the period from January 1, 2003, through December 31, 2006, Defendant
3 violated the False Claims Act, 31 U.S.C. §3129(a)(1) and (a)(2), over 15,000 times, by
4 knowingly presenting or causing to be presented materially false or fraudulent claims to the
5 Government for payment for directly measured LDL analyses (the False Claims), and knowingly
6 making and using, or causing to be made and used, materially false or fraudulent records or
7 statements to get the False Claims paid (the False Records or Statements),

8 23. The False Claims were materially false or fraudulent because defendant either
9 with actual knowledge of the falsity, or in deliberate ignorance of the falsity, or in reckless
10 disregard of the falsity, certified or caused to be certified on Form HCFA 1500 or its equivalent
11 that the services described were medically appropriate, when the defendant either actually knew,
12 or acted in deliberate ignorance of the fact, or acted in reckless disregard of the fact, that the
13 services described were not medically appropriate.

14 24. The False Records or Statements were materially false because defendant either
15 knowingly falsely, or in deliberate ignorance of the truth, or in reckless disregard of the truth,
16 recorded or stated that the services described were medically appropriate, when the defendant
17 either actually knew, or acted in deliberate ignorance of the fact, or acted in reckless disregard of
18 the fact, that the services described were not medically appropriate.

19 25. Defendant intended the False Claims and the False Records or Statements to be
20 material and to be relied upon, and they were essential to defendant's fraudulent scheme,
21 because the False Claims and the False Records or Statements were necessary to support the
22 payment or approval of the False Claims by the Government.

23 26. The United States was damaged by defendant's actions because payments were
24 made to defendant from the United States Treasury by the United States on the basis of the False
25 Claims or the False Records or Statements that would not have been made in the absence of
26 defendant's False Claims or the False Records or Statements.

SECOND CLAIM FOR RELIEF

Unjust Enrichment

27. The United States adopts and incorporates by reference the allegations of paragraphs 1 through 26 above as though set forth fully herein.

28. During the period from January 1, 2003 through December 31, 2006, the United States conferred a benefit upon MMG by paying reimbursement to MMG for the False Claims.

29. MMG was thereby unjustly enriched, because it appreciated, accepted and retained the benefit conferred upon it by the United States under circumstances in which it would be inequitable for MMG to retain that benefit.

30. The last transaction, last item charged, or last credit given in relation to the False Claims occurred less than four years prior to the date of filing of this Complaint.

THIRD CLAIM FOR RELIEF

Payment by Mistake

31. The United States adopts and incorporates by reference the allegations of paragraphs 1 through 30 above as though set forth fully herein.

32. The United States made payments to MMG under the mistaken belief that MMG was entitled to those payments, which was material to the decision to pay.

33. MMG received the payments which were made by the United States under mistake, and MMG is under a duty to return those payments to the United States.

JURY DEMAND

The Government demands a trial by jury on all issues in this case.

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1 WHEREFORE the United States requests the Court to enter judgment in its favor and
2 against defendant and to order the following relief:

3 1. Triple the amount of the United States' proven damages under the False Claims Act;
4 2. Civil penalties as required by the False Claims Act;
5 3. Restitution under the common-law theories of unjust enrichment and payment by
6 mistake;
7 4. The costs of this action; and
8 5. Such further relief as the Court deems just and proper.

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10 Respectfully submitted this 16th day of March, 2009.

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12 GREGORY A. BROWER
13 United States Attorney

14 By /s/
15 ROGER W. WENTHE
16 Assistant United States Attorney
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